MEDICAL RECORDS RELEASE FORM

Administered by A.G.I.A., Inc. PO Box 9060 Phoenix, AZ 85068-9060 Phone: 877-883-8800 • www.claimformassist.com

TO BE COMPLETED BY THE PATIENT OR AUTHORIZED REPRESENTATIVE

Patient Name:
Birth Date:
Social Security No. (optional):

Patient's Full Mailing Address:

City:	**State:**	**Zip:**

This authorization will expire on the following:
Date: 24 months from date of signature

Purpose of disclosure: determining eligibility for insurance benefits

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. A photo copy or facsimile of this form is as valid as the original and I can get a copy of this form after I sign it upon request.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _______________(Initial) If not applicable, check here. ❑

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**

THIS SECTION FOR INTERNAL USE ONLY

Release Information From:	**Release Information To:**		
Provider's Address:	**Address 1:**		
	Address 2:		
	City:	**State:**	**Zip:**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ❑ No, then you may check as many items below as you need.

Request for information as listed below for these specific dates: ____

❑ All PHI in medical record	❑ Operative Information	❑ Labor/delivery sum.
❑ Admission form	❑ Cath. lab	❑ OB nursing assess
❑ Dictation reports	❑ Special test/therapy	❑ Postpartum flow sheet
❑ Physician orders	❑ Rhythm Strips	❑ Itemized bill:
❑ Intake/outtake	❑ Nursing Information	❑ UB-92:
❑ Clinical Test	❑ Transfer forms	❑ Other:
❑ Medication Sheets	❑ ER Information	❑ Other:

Authorization for Release of Health-Related Information to Securian Life Insurance Company, administered by A.G.I.A., Inc

Authorization Complies with the HIPAA Privacy Rule.

For the purpose of determining eligibility for insurance coverage and benefits, I authorize any medical professional, pharmacy benefit manager, psychologist, social worker, hospital (including Veterans Administration Hospital) clinic or other facility, insurance company, consumer reporting agency, employer, the Social Security Administration, Internal Revenue Service, coroner/medical examiner, police department or other organization or person which has any information on to give all such medical or nonmedical information to Securian Life Insurance Company, administered by A.G.I.A., Inc. (Company) or its authorized representative. This shall include, but not be limited to, information regarding any medical or health history including all consultations, diagnoses, prescriptions, treatments, and tests. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This authorization shall be valid for 24 months from the date it is signed. I have read it and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time except to the extent that the Company has taken action in reliance upon the authorization prior to notice of revocation. Revocation of this authorization by me in writing shall be effective upon receipt by the Company. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.